

PSYCHIATRIC CLINICAL NURSE SPECIALISTS, NURSE PRACTITIONERS, OR THE NEW PRACTICE DOCTORATE: MEETING PATIENTS' NEEDS?

By: Beverly K. Hogan and Mona M. Shattell

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Psychiatric clinical nurse specialists (CNSs) were first introduced in 1954 by Hildegard Peplau as valuable contributors to the care of the chronically mentally ill (Spray, 1999; Wheeler, 2004). Peplau demonstrated that the therapeutic nurse-patient relationship shaped treatment outcomes. Then, during the years following mental health reform and deinstitutionalization, a golden opportunity arose for psychiatric CNSs to further their contribution in the community care of these patients.

Community mental health center patients frequently present with problems beyond the competence of baccalaureate prepared case managers and other non-medical psychotherapists. As complex illnesses including substance use and comorbid medical problems have become more common among patients in community mental health centers, the need for qualified professionals has grown. Psychiatric CNSs are excellent for working with patients with complex medical and psychiatric problems (Miller & Martinez, 2003). Now many psychiatric CNSs in community mental health care have been relegated to managing medication clinics and fielding crises for psychiatrists. Yet, most psychotherapy positions in community mental health centers are occupied by social workers and licensed professional counselors. Psychiatric CNSs have therefore found private psychotherapy practices, or faculty or administrative positions more attractive. Further, some community agencies have cut psychiatric CNS positions, leaving large gaps in the appropriate care of psychiatric patients in the community.

This gap has been partially filled by adult and family nurse practitioners (NPs) who manage patients' medical problems. Sometimes, adult and family NPs also assume responsibility for patients' psychiatric conditions, providing care patients might not otherwise receive—including patients with anxiety disorders and depressive illnesses who are turned away from overtaxed mental health centers because they do not meet criteria for a “serious” mental illness. Family and adult NPs thus have responded to a need that others did not address.

As graduate education in psychiatric mental health nursing has aligned core courses with NP preparation (Cotroneo, Kurlowicz, Outlaw, Burgess, & Evans, 2001), concerns about overlapping roles between NP specialties and psychiatric CNS have emerged (Holmes, 2006; Moller & Haber, 1996). Some psychiatric NPs focus on providing medications, while others focus on psychotherapy. There is wide variation in addressing psychiatric patients' comorbid and iatrogenic medical conditions. Some psychiatric NPs solely treat psychiatric symptoms and refer

medical problems elsewhere. Others address both medical and psychiatric symptoms simultaneously, because problems and treatments can interact and affect one another.

Now, as advanced practice psychiatric nurses, we have been given another chance to help manage the unmet medical needs of this population. Psychiatric CNSs have long been warned of the potential for role confusion, ambiguity, and even the disappearance of their specialty (Chevalier, Steinberg, & Lindeke, 2006; Holmes, 2006; Lauder, Meehan, & Moxham, 2004; McCabe & Burman, 2006; Olson, 2004). Currently, we have the Advanced Practice CNS and the Advanced Practice Psychiatric NP. Core competencies for the entry level psychiatric NP have been established (National Panel for Psychiatric Mental Health NP Competencies, 2003), yet the degree to which either of the advanced practice groups will address coexisting medical problems of psychiatric patients is unclear. This will greatly impact the care of psychiatric patients. We know, for instance that psychiatric patients have a shorter life expectancy and are more prone than others to cardiac and metabolic abnormalities (McDermott et al., 2005). It is difficult for medically trained practitioners to decipher the complexities of communication presented by psychiatric patients with a disturbance of thought and communication processes; thus it makes sense that a practitioner with the interpersonal skills and knowledge to respond to this type of patient should also be the one to be concerned with coexisting medical needs (Lambert, Velakoulis, & Pantelis, 2003; Miller & Martinez, 2003).

Although psychiatric NPs have documented equal or superior effectiveness to their psychiatrist counterparts, consumer satisfaction has been described in vague terms like “better relationships,” “more down to earth,” and “more holistic” (Elsom, Happell, & Manias, 2005; Wortans, Happell, & Johnson, 2006). These characteristics cannot be claimed as unique to nursing. Psychiatric NPs must articulate their unique *nursing* practice beyond basic psychiatric medication management and good relationship skills.

The new Doctor of Nursing Practice further complicates matters. With the intent to make the DNP the new credential for nurse practitioners, there is the potential for greater role confusion. Will the new DNP be better prepared for complex psychiatric and medical comorbidities, or are we just confounding the issue?

Have advanced practice psychiatric nurses' roles advanced the well-being of patients? Advanced practice psychiatric nurses—whether CNS, NP, or the new DNP—have a responsibility, in our opinion, to maintain a knowledge base that incorporates both basic medical and psychiatric needs. The time is long past when we can afford to attend only to the presenting psychiatric illness. With the move toward holism, we can greatly impact the quality of life of the psychiatric patients in our care. Advanced practice psychiatric nurses must not compartmentalize specialist functions; we must integrate them and provide competent, coordinated health care for our psychiatric mental health consumers.

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